



Commission to Study Mental & Behavioral Health

Written Testimony – January 11, 2022



January 11, 2022

To: Commission to Study Mental and Behavioral Health in Maryland

Re: MCAA Position on the Danger Standard for Psychiatric Involuntary Hospital Admission

We praise the Commission for its interest in removing barriers to treatment for mental illness. Precisely because we agree with this goal, MCAA cannot support the “danger standard” definition proposed by BHA in the 9-11-2021 Involuntary Commitment Stakeholders Workgroup Report.

The proposed language of the standard subtly leaves out ‘psychiatric deterioration’ and this perpetuates the criminalization of mental illness by creating barriers to timely treatment. If hospitalization is denied for individuals in need of treatment, they decompensate with progressive judgement impairment resulting in legal involvement and incarceration for minor or serious crimes, thus creating victims and impacting the community. The burden of treatment and management has been wrongly displaced onto jails instead of psychiatric hospitals where they should be treated. Without proper staffing and resources, jails are burdened with complex challenges affecting all areas of jail operations. Jails are forced to face the monumental task of keeping this population alive while incarcerated, while being the least appropriate treatment setting.

After sentencing, if individuals refuse medication in jail, their only hope for hospital treatment is to decompensate further until two jail physicians certify that they meet the danger standard for hospitalization. Even then, certified patients fall ‘last’ in MDH’s priority group for hospital admission. MDH gives priority to Court ordered competency evaluations since they have a monetary penalty for evaluation delays.

Patients that deteriorate in jail due to treatment refusal are the most at risk for health complications, self-harm or suicide, increasing liability for jails. This high-risk population requires the need for restrictive housing to ensure their safety and that of others. If displaying extreme psychotic behaviors such as feces smearing, it is challenging and labor intensive for staff to care for them. Their management is extremely costly and complex in jails as it impacts staffing coverage, supervision, classification, housing, and general jail operations. Overtime pay becomes financially taxing when one-on-one observation and special details to the local ER are required following self-harm attempts. Staff stress is created as they witness the deterioration and suffering of inmates but are helpless to facilitate needed hospital treatment.

Additionally, assigning duties to jail staff that should be performed by trained hospital personnel adds to staff stress and increases liability.

A key concern for MCAA is that neither BHA nor the Governor reached out to MCAA to seek out representatives who could actively participate in the Stakeholders workgroup, or to become members of the Commission. Jail representatives could have provided insight on the overwhelming problems and challenges faced by the mentally ill and jail staff as a result of incarceration versus timely community hospital admission. Because of treatment refusal while incarcerated, and because of the danger standard limitations that result in denial of hospital admission, some inmates may leave the jail in worse condition than when they were first booked. It needs to be recognized that jails are not hospitals to provide the level of care required to stabilize patients not receptive to treatment.

MCAA therefore takes the position that 'psychiatric deterioration' should be included in the danger standard definition currently proposed by BHA to prevent the criminalization of mental illness and finally remove barriers to humane and timely treatment for the mentally ill.

We appreciate your time and consideration in this matter and all matters of mutual concern. If any additional information is required, please do not hesitate to reach out to MCAA Past President Terry Kokolis, Warden, Talbot County Department of Corrections, (410) 770-8120, and/or Ms. Patricia Sollock, MA, LCPC, Mental Health Services Director, Anne Arundel County Detention Facilities, (410) 222-4220, and I, Deputy Warden Mary Ann Thompson, St. Mary's County Detention and Rehabilitation Center, at (301) 475-4200 ext. 72276, email: maryann.thompson@stmarysmd.com.

Sincerely,


Mary Ann Thompson
President

CC: Warden Terry Kokolis, MCAA Past President
Ms. Patricia Sollock, MA, LCPC, MCAA Mental Health Committee
File

Jaclyn Thomas

Mother of 5

Resident of Montgomery County Maryland

I am writing to you as the mother of 5 children. One of my sons has been diagnosed with a serious, life-long debilitating mental illness. Because of current Maryland laws, I am helpless to watch him deteriorate and most likely die. I am also writing as a citizen of this great country that I have the privilege to live in who has seen the devastating effects caused by unforgivable holes in our mental health care system, especially in Maryland. It has been said that Maryland is one of the worst places to live if you have a family member who is mentally ill.

Maryland is one of the three states in this country that does not mandate assisted outpatient treatment or discharge care subsequent to an inpatient psychiatric hospitalization. I have watched helplessly as my child fell through the cracks of this broken system and will not sit back and watch silently as this continues to happen to others. Mental healthcare, and continued support for the mentally ill, should be a right and not a privilege. Maryland laws and the review of their effectiveness should take into consideration that, inaction to change these laws actually fails to uphold human and civil rights, the very rights these laws are designed to protect.

My son, who is now 18, is battling psychosis. This battle affects his entire family, his school community, and his friends. Psychosis is a disease like cancer, which is often terminal and puts his life at risk. There is no cure for psychosis, and without treatment, just like cancer, his prognosis gets more dire the longer it's left untreated. The only way my child, and my family have a chance at a productive life, is if continued aftercare with assisted outpatient care that is mandated.

I first realized my son had a serious problem, when he disappeared one bleak January night in 8th grade, after saying he was going to kill himself, and waited 5

hours with no shoes on to come back to the house, despite a search team and amber alert. That was the first time I spent the night with my 14-year-old child in an adult hospital emergency room to await psychiatric evaluation in the morning from a pediatric emergency room doctor. The pediatric emergency room physician dismissed us to go home with no follow up care or plan. Such was my introduction to the mental health care system in the state of Maryland. Since then, my child has had over 8 inpatient hospitalizations with varying levels of help, but always the same outcome, zero assistance or mandated care or follow through with either medication or continued psychiatric care.

While my son was a minor, I spent millions of dollars trying to intervene while I still legally could, by finding the best doctors, care and residential programs. I hired consultants, worked with the best psychiatrists and tried everything to save my child's life. Unfortunately, due to the nature of the disease, he has relapsed often and required hospitalization. I have had to hospitalize my son eight times, twice by going to get emergency petitions, some by crisis intervention and others by emergency responders. Most of the hospitals lacked the knowledge to see the more subtle clues of ongoing untreated psychosis. Doctors look for the obvious signs of psychosis, which can include hallucinations or delusions, but in my child's case, he did not have these. He has disorganized and tangential thinking which keeps him from having the ability to make sound decisions or avoid harm unless he has medication and support. Going through the revolving doors of these hospitalizations with no mandatory plan of support afterward, causes unnecessary trauma to the patient and the family, and breaks the trust between family members seeking to get their loved one care. This can lead to homelessness and illness that then becomes the responsibility or liability of the state as well as in some cases horrific acts of violence or criminal activity.

Now that he is over eighteen years of age, I have to watch helplessly as his treatment becomes undermined by the very system that should be protecting him. All of my actions and desperate attempts to save his life are in vein if a system allows him to

be lost, at risk, and in a constant state of crisis because it does not recognize that he requires mandated aftercare as component of hospitalization. Who is protecting his rights? Who is examining the wasted resources of an inefficient system? Who is studying the needs of doctors and hospitals, which are not equipped or supported with this kind of medical care? Our system is crippled and breaking under the lack of attention paid to this healthcare crisis. I have done everything humanly possible to help save my child, but unless the laws change in Maryland, my child and countless others will fall through the cracks, and will end up in jail, drug addicted or dead. Please change the laws so that my child will get the continued care that he needs, despite his grave lack of insight into his own condition, or ability to avoid extreme risk or be taken advantage of those looking to exploit the most vulnerable.

There are two major flaws that contribute to the revolving door and lack of progress for our countries mentally ill and their families, often having devastating effects not just on them but countless others effected by their lack of treatment.

The first major problem is the impossible lengths a citizen has to go to get their mentally ill loved ones into care. The first line of help is getting them into a hospital. In order to do this the family member has to be either suicidal or homicidal. What about the individual struggling with psychosis, who is so disorganized they are incapable of keeping themselves safe or making safe decisions. What about the student who is clearly in crisis but the schools hands are tied and as long as they haven't made comments alluding to either of these two extremes, no one can intervene. When great planning and lengths are taken to get someone into a crisis evaluation, if a patient denies either of these two extremes (which they often do to avoid being committed), they fall through the cracks, and the cycle continues, and tragedy ensues. I have found that often the emergency room personnel responsible for spotting the criteria necessary to commit an individual, are not well enough trained and miss the majority of the subtle cues of mental illness at its beginning, when it is the most treatable. Mentally ill patients denied comprehensive care, at some point, give up not seeing the light past the trauma and

give into addiction as the only way to cope. Many end their lives, and have told their parents, as my child did, "I hope I get shot, I just want this to end". No parent after desperate a search to find help should ever have to hear that. There needs to be a more structured and supported procedure plan for emergency room doctors, and better training for those doctors so that they can spot the subtle signs of mental illness. We need to pay our doctors more and empower more creative minds and create a system capable of helping change this cycle. The law needs to change to allow someone to be assessed not just because of suicidal or homicidal statements, but also as an individual's ability to stay safe, and not put themselves or others at risk. I recently called crisis after finding my 18-year-old son aimlessly wandering dark roads with no sidewalks in the middle of the night, with no wallet, ID, and no money in the dead of winter. It took planning and a miracle to get my son to stay in one place so that a crisis group could evaluate him. The crisis evaluator came, talked to my son for 45 minutes and then, because my son made no claims to hurt himself or others, the crisis evaluator gave him his card and left. Minutes later, my son tore up the card and walked out onto a highway, wearing the same clothes he had been wearing for two weeks, again with no money, nowhere to go in the winter, choosing homelessness and addiction over treatment. No parent should have to have an experience like, when counting on help in a crisis.

The second major hole in this system is the lack of coordinated care and mandated after care. I have seen my child go in and out of 8 psychiatric hospitals in the last few years. Each time we are starting from scratch as far as records or mental health history. Even with a top psychiatrist and countless documents, no comprehensive evaluation on past history is done. In many cases, there is no record of past medications tried, or clues to a more effective diagnosis from their history. A hospital uses in many cases the information they get out of a patient. That statement is often inaccurate. Either the patient is not able to properly recall his treatment, or they are guarded and have learned how to get out of a hospital quickly by knowing what to say, denying any of the reasons they went in, and avoiding accurate diagnosis and the right life saving medication. I have spent thousands of

dollars at UPS and Kinko's copying records and dropping off at the hospital records and in many cases, they were not requested or even read. Each time my child has gone into a hospital there has been no follow up care or coordinated effort to ensure their safety after discharge. The last three times my child was discharged there were no viable discharge plan, and nothing mandating it. When he was a minor, the social worker at Sheppard Pratt had not found a partial hospitalization day program or outpatient program that was viable. The choices on the list had all denied him for various reasons. There was then no discharge plan and I was told to go pick him up by 11am and bring him home with my other 4 children with no plan in place to help him, or my family. I told them I would not pick him up without a discharge plan that was viable, and was told that If I did not come at 11am to pick him up, that they would call social services and report me as having abandoned him. The sad thing is countless people I have spoken to abandon their children to the state, as the only way to get their child help. How is it that we live in this country and parents who love their children have to be desperate enough to get their children the help they need, that they face social services charges and give their children up to the state. The other options are to apply through the system for residential placements, which require extensive complicated paperwork, calling numbers with no answer for weeks, and being told that its near impossible given the overcrowding, the age of my child and unlikelihood he would get in. What are families supposed to do in these situations? The Unites States of America can do better than this. I had wanted to file a complaint against the hospital, but as a single mother of five trying to manage my sons care on my own, I did not have the tools nor the time to manage to do that, and that should not be the way that this country affects change. A change that needs to be made is to have a coordinated plan for aftercare once it is mandated. Each person in the US that is diagnosed with a major medical disease of the brain, needs to have an appointed caseworker that is familiar with their history and can openly communicate with family, support systems and hospitals, and emergency personnel. This mental health care crisis requires comprehensive history evaluation, to assess someone's safety and risk to themselves. If a doctor is unaware and uninformed about their past health history, how is an individual going to get life saving proper

treatment. In Maryland someone with impairment to their judgment and lack of insight because of their disease, should not have to be at risk and endanger themselves and make loved ones have to stand by and watch the grave consequences. There needs to be caseworkers that follow clients care and assist families with mentally ill individuals with their continued care and through crisis situations. You can hire these caseworkers through private companies, but they are prohibitively expensive, and unaffordable.

If more funding was put in place to provide these life saving measures, it is my belief that countless lives would be saved and tragedies would be preventable, giving mentally ill individuals the chance to live fulfilling lives. Families of these individuals should no longer hope they commit a crime to get access to mandated treatment, or be forced into the position of abandoning them to the state in hopes to get treatment. One in 5 adults in the United States have experienced a serious mental illness. Families and individuals suffering should not be left alone, abandoned and stigmatized by the very government that was put in place to help them. As a desperate mother, and a concerned citizen I am urging you to make these changes.

The life lived in the battle of mental illness is often walked alone. Unlike other diseases when support is outpoured, the brave ones who step in to help a family with mental illness are few. Mental illness is feared, judged and pushed under the rug. Government has not acknowledged or stepped in to do anything to fix this broken system, leaving the heavy burden on the family or these vulnerable individuals. Our mental hospitals are full. Our emergency rooms have become crippled with patients waiting for available beds in psychiatric hospitals in desperate need of treatment. Mentally ill patients like my child find themselves in a traumatic, revolving door cycle that will only be transformed by the leaders of this nation understanding this crisis and the bravery it will take to not sweep this problem under the rug any longer. Our country is one of the most powerful in the world and, yet at the same time the most reluctant to deal with our own weakness. A

preventative and revolutionary system needs to be enacted to assist individuals who are incapable of helping themselves, and at the very least, empower family members be able to help them.

Thank you for your consideration,
Sincerely,

Jaclyn Thomas

My name is V. Susan Villani and I am a family member and a recently retired child psychiatrist with over 40 years of experience in the field. While this is my first time testifying, it will not be my last until there are significant changes in the laws in Maryland regarding access and treatment for those with chronic and persistent serious mental illness. This should begin with addressing inadequacy of the danger standard of the current involuntary treatment law which is commonly interpreted as requiring imminent danger to self or others. **The law as it stands now in terms of neuroscience is unsound and is contributing to brain damage and functional deterioration by preventing the treatment of psychosis.** The danger standard should be defined to include psychiatric deterioration resulting in the inability to care for oneself and the reasonable expectation that continued lack of treatment will result in self harm, which includes psychiatric deterioration, or harm to others. Personal, medical and psychiatric history, if available needs to be considered in making this assessment and it should be made explicitly clear that the danger need not be imminent.

My family member has been ill for over 15 years during which time she has had a progressive downward course in terms of ability to function independently, care for herself, and be a member of a community. This is in spite of our seeking and getting treatment in the best settings the state has to offer. The settings and professionals who work within them are limited in what they can provide for her due to the overly restrictive nature of Maryland's commitment law which does not take deterioration into account and instead focuses solely on immediate danger. It does not matter if she is paranoid, not taking her medications, has no food in her apartment, does not know what day it is, or as occurred most recently, has taken an "accidental overdose" of her medication due to her impulsivity and lack of awareness of what she was doing. We watch her decline and plead with her outpatient team to hospitalize her only to be told, "just because someone is sick does not mean they can get into a hospital." **For no other illness in medicine is the criteria near death.**

Recently I was told that if a family goes to court for an emergency petition the judges are "more sympathetic" and likely to grant for deterioration. This seems odd to me that judges are more sympathetic than health care professionals. And it is obviously much more difficult to go to court than a hospital and has implications for how the family member may feel towards those who sought the petition.

As we have watched our family member's cognitive and social abilities decline over the past decade, the science has become increasingly clear that this is largely the result of brain damage caused by untreated psychosis. Her delays in treatment have been the direct result of the narrow interpretation of Maryland's danger standard. While we wait for her to meet the imminent danger interpretation, there is ongoing damage to her brain. She is not only at risk of harm due to her poor judgement, impulsivity and paranoia, but over time she loses cognitive ability and her chances of recovery to baseline are less. **The law as it stands now ignores and contradicts scientific knowledge and is contributing to our family member's overall decline.**

It has been suggested by another family member that we move our family member to a different state where treatment is not as restrictive as in Maryland. Clearly that is not an option for many people, nor should it be an acceptable alternative plan. State of the art mental health care and mental health laws should be available to all citizens of Maryland. I plead with the Commission to recommend to the Governor to move swiftly to define the danger standard for involuntary treatment to include a psychiatric deterioration standard, consider pertinent history, and make explicitly clear that the danger need not be imminent.

Dear Commission on Mental and Behavioral Health,

Thank you for your important work on mental and behavioral health in Maryland and for allowing me to provide written testimony.

I am a civilian with the Department of Defense (DoD), supporting the U.S. military mission in Germany. My family and I have been stationed in Wiesbaden, Germany, since May 2021.

My eight year old daughter has been suffering from mental health issues, including anxiety, depression, and OCD, and (given covid) was seeing a licensed psychologist virtually in Maryland since the end of 2020. The benefits of virtual therapy were clear during that time until we left for Germany. Since we left Maryland, my daughter has had no access to therapy, and a decline in her mental health is evident. Obtaining therapy here in Germany is very difficult for several reasons: 1) lack of professionals trained in child and adolescent psychology, 2) long waitlists/waiting times for care, and 3) difficulty with the language barrier. Healthcare on the military base is not available to DoD civilians.

When we moved to Germany, we were hopeful that my daughter's current therapist would agree to continue to see her virtually, since my daughter had progressed so well under her care. However, we were told that Maryland's regulations for Psychologists state that a therapist cannot practice outside of Maryland unless permission is gained from the psychology licensing board where the patient resides. In the case of Germany, obtaining this permission is impossible. Both us and the therapist have reached out to German Psychological associations for assistance, with no response. Furthermore, the language barrier makes it extremely difficult to determine whom to contact and/or how to obtain such permission.

As I'm sure you are aware, there is a mental health crisis in the military community. The isolation resulting from covid, coupled with being in a foreign country away from family and friends, makes it especially difficult for those struggling. Therefore, it is my request that the commission remove any and all barriers to virtual mental health access in Maryland, especially for military personnel stationed overseas. I am still a legal resident of the US and Maryland, and pay both federal and state taxes. Additionally, I have observed that my coworkers who have legal residence in other states are able to continue to see their therapists virtually.

Please let me know if I can provide any further information on our situation, and thank you sincerely for your help.

-Jacqueline Seiple

I agree with Evelyn Burton's commentary, ["Treatment before tragedy; reform MD. Involuntary commitment law,"](#) (Dec. 13), based on my recent personal experience.

In my family's case, involuntary psychiatric hospitalization could definitely be a potential lifesaver for my family member who was homeless and psychiatrically deteriorating, unable to comprehend the need for medication. However, because "danger" is not defined in Maryland's standard for involuntary evaluation and hospitalization, my loved one was allowed to deteriorate to the point where he refused available shelter in freezing weather and was unable to obtain food and protective clothing.

On Dec. 13, I had to go to a Maryland District Court to get judicial approval for an "Emergency Petition for Evaluation" for my homeless family member who was in crisis. Over the course of the prior three days, my family member had an interaction with the city police and another with the mobile crisis unit. However, neither were willing to issue a petition to have him involuntarily transported to a hospital emergency room for evaluation for involuntary hospital admission because they did not believe he met the danger standard — yet. Apparently, according to their interpretation, psychiatric deterioration was not considered a danger of harm to self. My family member remained in crisis, homeless on the street and in danger.

Fortunately, the danger standard was interpreted differently by the judge who granted the petition for evaluation. If I had not gone to court, who knows the fate of my loved one. I prayed, and, fortunately, the emergency room doctor interpreted the danger standard the same way as the judge and agreed to complete the certifications for involuntary hospitalization. So the hospital door was open this time.

When petitioning is done by the police or providers, it does not risk damage to family relationships which are very important for support and recovery of our loved ones. However, I did what was necessary to help my loved one to get the medical help needed.

My experience is a clear example of how the danger standard interpretation varies widely. Service providers, the police and judges need the necessary guidance to understand that the law does not require imminent danger and that psychiatric deterioration is a form of danger to self. I echo Ms. Burton's statement that "families are counting on the commission and Governor [Larry] Hogan to recognize that treatment delayed is treatment denied. Tear down this legal barrier and enable treatment before tragedy."

D. Bennett, Capitol Heights

I am writing to ask the commission to create a standard and explicit definition for "danger" as it applies to involuntary hospital commitments. This will allow families and caregivers, law enforcement, hospital, and justice system officials to understand when to use involuntary commitment, and to allow it to be used appropriately. Otherwise, interpretation of "danger" is left up to discretion, which puts everyone in an unnecessarily difficult position, and the patient (and sometimes their community) in danger.

Of course, the hope and desire is that no one will deteriorate to the point of needing to be hospitalized against their will. However, when someone does need hospital treatment, in my experience as a family member, caregiver, and clinician, it is important and necessary for those of us in Maryland to have clear, consistent and direct guidelines on when this action is, and is not, permitted.

A danger standard definition should include:

- The danger is reasonably expected to occur in the foreseeable future and need not be imminent
- Psychiatric deterioration is a form of "danger to self"; and
- Any available personal, medical and psychiatric history must be considered — not just the person's behavior in the present moment.

Lastly, I know of people who have been traumatized by involuntary commitment. The standard of care in hospitals also needs much improvement.

Thank you,

Jill

Dear Commissioners,

I am a Marylander writing in my capacity as caregiver of a family member with a mental illness, and as a volunteer with the National Alliance on Mental Illness, Montgomery County affiliate. One of my NAMI roles is as a **support group facilitator for caregivers of persons with mental illness**.

In this capacity, I regularly hear the frustrations, anxieties, fears, grief and panic of concerned family members who have been **rendered powerless to obtain appropriate interventions for their adult loved one with a mental illness because of the inadequately defined “Danger Standard” for involuntary commitment in our state of Maryland**.

They are terrified for the welfare or even life of their ill loved one, and sometimes also for those around the sick individual, because **they can clearly see the signs, often recognized from prior experience, that the sick person’s condition is unraveling into crisis**.

However, the lack of a more comprehensive definition of “danger” than **the current extreme interpretation of “imminent” danger to self or others** (i.e. suicidal or homicidal behavior), prevents a **“treatment before tragedy”** approach that will benefit us all.

I am thus asking the Commission for Mental and Behavioral Health in Maryland to recommend amending **the “danger standard” to be more explicitly comprehensive**:

We need a more common-sense definition of “danger”, one that includes “psychiatric deterioration” as a form of danger to self that all first responders, medical providers, and courts, will be able to consistently act on. We need a definition where **prior history, not just a “snapshot” of immediate presentation**, is taken into consideration.

25 other states have already adopted a “psychiatric deterioration” standard and have not had their response systems overwhelmed as a result. Given that about 1 in 4 of MD prison inmates, and homeless individuals in MD, suffer from mental illness, and that early intervention is associated with better outcomes for serious mental conditions, it behooves our state to “follow the data” and make it easier to get our mentally ill into treatment.

Improving the danger standard definition for involuntary commitment to encompass “psychiatric deterioration” would be an important step in the right direction, particularly since **some of the most serious psychiatric conditions are characterized by anosognosia**. This means the ill person is unable to themselves grasp that they are mentally ill and need treatment. As a society, we need to be able to make it easier for them to be treated early, to minimize lasting damage to themselves, optimize their chances for a good quality of life in our community, and definitely before a mental illness-related catastrophic event occurs.

Thank you for your consideration of my remarks.

Myra Jacobs

Hello, my name is Karen Cook. I have children and older adults in my family who suffer from a mental illness.

I request the commission to recommend the following revisions to the definition of the danger standard for involuntary psychiatric treatment proposed by the Behavioral Health Administration:

- a. The danger need *not* be imminent;
- b. Psychiatric deterioration, is a form of “danger to self”, such as delusions, inability to reason or loss of self-control,
- c. I recommend that the consideration for involuntary treatment include any available personal, medical and psychiatric history — not *just* the person’s behavior in the present moment.

Thank you for your important consideration of the specific language used in this definition.

Karen Cook

We understand the Commission is reviewing data concerning the requirements for involuntary commitments under current law and practice in Maryland and will make recommendations soon to the Governor. We do not know details about relevant involuntary commitment conditions in Maryland, but we do have a son who is living with a mental illness in Brussels, Belgium.

When we became aware our son was neglecting his hygiene and occasionally sleeping on the street, we retained a Brussels-based attorney and, through our attorney, petitioned a local magistrate (Judge de Paix) to involuntarily commit him to a psychiatric hospital under Belgium law. Our son is and has always been non-violent, is not a threat to others, and has never been suicidal (his current age is 40 and he has suffered from a mental illness since completing his 6th year of an NIH-sponsored MD/PhD program at age 30). But our attorney argued successfully to the Judge de Paix that our son's inability to engage in proper hygiene, and the obvious continuing deterioration in his condition, represented a danger to himself. This clearly was the correct decision because our son required immediate medical help and was in no frame of mind to seek it out himself. The judge committed him for 40 days to a respected psychiatric hospital in Brussels and he received medication and competent psychotherapy. He recently was discharged and it appears his thinking is now more grounded in reality. He is more "persuadable" concerning the "right thing to do" and seems to be willing to cooperate with the outpatient team assigned to provide continuing care. There are no guarantees with mental illness, but we believe there is a fair chance improvement will continue. But without the Judge de Paix's intervention, none of this would have occurred and we can only imagine what would have happened.

We are not in a position to know what revisions of current involuntary commitment laws and procedures are sensible for Maryland. But we can testify from experience that too strict a standard which focuses only on "imminent harm to others or probability of suicide" does not advance the interests of the person who is mentally ill, that person's family, or the public. Who knows what would have happened to a person like our son who was not an imminent danger to others and not suicidal if the Judge de Paix had not required him to be treated. He would have continued to deteriorate and might have become a ward of the state. While who qualifies for involuntary commitment should primarily be based on doctors' assessments, they should have broad leeway to make medical judgments. They should not be constricted by artificially narrow legal constraints. So any recommendation the Commission makes to the Governor we hope will reflect the need for flexibility and deference to qualified doctors.

We hope our experiences with our son in Brussels is helpful to the Commission.

Respectfully submitted,

David and Barbara Levitt

Hello,

My name is Sonal D. Patel. I am a resident of Montgomery county. I have an adult daughter with mental illness.

I hereby support and request commission to recommend the following revisions to the definition proposed by the Behavioral Health Administration:

- [a] Make explicit that the danger need *not* be imminent;
- (b) Include psychiatric deterioration, as a form of “danger to self”; and
- (c) Include a requirement that any available personal, medical and psychiatric history must be considered — not *just* the person’s behavior in the present moment.

My daughter stopped eating when going through a relapse of anorexia nervosa, in the winter of 2020 precipitated by obsessive compulsive thoughts and behaviors. She was a completely different person, she cried all the time, locked herself in the room, and couldn't sleep or function, including making a proper judgment or taking a decision. Her psychiatrist at the time told us that she could not be hospitalized because she is not suicidal or homicidal mean she is not "danger to herself or others".

If this was defined differently as proposed above, her care wouldn't have been delayed. We had to watch her deteriorate in front of our eyes before her psychiatrist took action.

I urge the commission to consider a broader view and interpretation of "danger to oneself" and change the definition so that families of mentally ill patients can get proper care for their loved ones in a timely fashion and avoid an adverse outcome.

Sincerely;

Sonal Patel

I am the guardian of a mentally ill adult, and it is extremely frustrating and painful to try to help them when they are engaged in activity which is dangerous to themselves, because the concept of danger is so very limited. If my relative is acting in a manner which upsets his neighbors as a result of his mental illness, and his landlord is considering evicting him, that is an IMMINENT DANGER to them, as it will result in them being homeless. If my relative has decided that eating is not necessary to their survival, that is an imminent danger to them. If my relative is in a stage of mental illness which leads them to think that driving on the highway when the gas gauge indicates that there is no possible way to get home, but they decide that God told them that they would be okay, that is an imminent danger.

When my relative has decided that their medication is not necessary, and they are in a state where they are acting inappropriately, and are not mentally able to take the necessary steps to keep themselves fed, clothed, bathed and housed, that is a danger to them. Even if they are not in a state where they may experience physical harm, being in a deteriorating mental state is a danger, because the longer they go un- or insufficiently medicated makes the likelihood of recovery more and more difficult.

Our family had a situation during COVID when my relative was not able to do any of the routine things which are so essential to a schizophrenic, and their mental health deteriorated rapidly. They were asked to move out of the house they were sharing because the illness has a sexual component, and there was inappropriate behavior. They didn't tell the family, and spent several weeks in sketchy motels, and my sibling spent months trying to find them housing. During this time, they checked themselves into Shepard Pratt, started to get on track and to get the medication dosages to a point where it was helpful, but checked themselves out of the hospital when they were nowhere near ready. It should not have been my relative's decision to leave the hospital when it was clear that they were in no condition to care for themselves, however the family had no say. It is a miracle that my relative's sexually inappropriate behavior has not resulted in them being assaulted by someone who witnessed it.

The standard of "danger" needs to take into consideration all of the various ways that a mentally ill person in crisis can harm themselves - physically, mentally, financially, socially and with regard to housing. It can't simply be "are they suicidal", "are they likely to kill or harm another person", but "are they mentally able to take proper care of themselves, and are they mentally able to act in their best interest?"

I am Catherine Mateer and I can be reached at 410-459-4397.

Comments to the Commission to study Mental and Behavioral Health in Maryland. for 1-11-21

My name is Liz Montaner and I am the mother of a 36 year old son diagnosed with schizophrenia. The definition of the danger standard proposed by the Behavioral Health Administration (BHA) in the Final Report of the Involuntary Commitment Stakeholders' Workgroup would **NOT** have helped facilitate needed hospital treatment for my son after his first psychotic break. This is because it does not include criteria for psychiatric deterioration and does not clearly specify that the danger need not be imminent. It would **NOT** have eliminated the need for us to ask him to leave home and make him homeless in a vulnerable psychotic condition in the hope he would then meet the danger standard.

After college graduation, my son began showing signs of psychosis. Unfortunately, his illness included a neurological deficit called anosognosia which prevented him from understanding that many of his thoughts were not reality based. He was unable to see a need for any psychiatric treatment and refused it.

Before we made him homeless, my son was clearly experiencing psychiatric deterioration with psychotic delusional thinking that anyone, with or without training could recognize. This would **NOT** meet the criteria proposed by BHA for involuntary hospital treatment. BHA accepts that "refusal of somatic care can create a danger to self". However, they blatantly discriminate against those with psychosis by ignoring that, rejection of psychiatric care can also create a danger to self. They acknowledge the extensive research supporting this but then choose to put their head in the sand, ignore the science and reject a psychiatric deterioration standard. This continues forcing families to make the excruciating decision to make their loved ones homeless to prove they are unable to meet their physical needs.

BHA has also chosen to ignore the recommendation of this Commission that the definition should clarify that the "standard of immediacy" is insufficient". BHA rejected "criteria for commitment that did not require an element of *immediate* danger. (Emphasis added). They state that "the criteria for involuntary commitment ..., should be based on current and acute issues ..., *not* because of the possibility that the lack of immediate treatment may lead to future harm..." They give no valid legal reason for this or justification for denying treatment to those critically ill.

Research shows that the earlier treatment starts, the better the long-term outcome. That was true for my own psychiatric emergency almost 40 years ago. I was placed in a psychiatric hospital within days of my first psychotic break, treated for almost three months and have never had another mental health incident. My son has not been as fortunate and will likely spend the rest of his life battling this horrendous illness.

Maryland received the absolute lowest numerical ranking given by the Treatment Advocacy Center in its evaluation of inpatient commitment laws of all 50 states. Lack of a grave disability and psychiatric deterioration standard and no clarity that imminent danger is not required contributed to the shameful score. BHA has clearly shown they are willing to ignore the science and don't care about many preventable tragedies. The Commission 2021 report makes no recommendation of its own on the danger standard. **Are you here just to be able to say you listened or will you follow the science and prove you care, by recommending changes to the BHA standard to make explicit that the danger need not be imminent, that personal, medical and psychiatric history should be considered, and a psychiatric deterioration standard be included to actually eliminate the barrier to care? Will you even discuss it publicly and tell families what YOU recommend?**

Dear Members of the Commission

My name is Krsna Vieira and I'm the older brother of a 27-year-old man who suffers from manic-psychosis. He is currently detained and receiving treatment at a psychiatric ward in Montgomery County so he can be made mentally competent to stand trial for violating a protection order. The onset of his mental illness occurred over 7 years ago and since then he has had several psychotic episodes often accompanied by aggressive, impulsive, and violent behavior which have resulted in encounters with police/EMTs and subsequent hospitalization. Unfortunately, in several of those instances, the doctors would deem him as not being an imminent threat to himself or to others and he would be discharged a few hours after being admitted to the ER. I feel that the inconsistencies in treatment response are in part due to the lack of clear standards in determining whether or not a person poses a threat to themselves or others. This email is a request that you make the much needed changes.

Please recommend a danger standard definition which makes explicit:

- (a) The danger is reasonably expected to occur in the foreseeable future and need not be imminent;
- (b) Psychiatric deterioration is a form of "danger to self"; and
- (c) Any available personal, medical and psychiatric history **must be considered** — not just the person's behavior in the present moment.

If you need clarifications or have questions for me, please email or call me on 240 5951843.

Thank you,

Krsna Vieira

Dear Commissioner,

My name is Ellen Kobler and I have a 62-year-old brother who has suffered from Schizophrenia for all of his adult life. He has worked extremely hard over the years to keep his disease in check. He has been institutionalized a number of times, and has also lived independently for many years, earning an associate's degree, and working part-time as a peer recovery counselor for mental health non-profits.

I can tell you from recent, agonizing first-hand experience, that it is critically important that the danger standard for involuntary commitment for individuals with mental illness be adjusted to include real-world risks that go well beyond the extremely limited parameters of imminent physical harm to themselves or others.

After decades of living independently in the community, my brother went into a tailspin in 2020, in part because the COVID-19 pandemic destabilized his life and shuttered the mental health program where he worked part-time as a peer counselor. He went off his medications, became homeless, was extremely agitated, acted erratically, stopped performing basic hygiene, and stopped paying his bills and eating regular meals. For hours on end, he drove around aimlessly, lingering outside of convenience stores to preach the gospel to strangers. Many of these locations in his self-described "parish" were in high-crime areas, and he is very lucky that he wasn't violently attacked, robbed or otherwise victimized. Clearly, to any reasonable person, this psychiatric deterioration and behavior was itself a "danger to self" and also a "danger to others," and a compelling reason to enable his family and caregivers to place him into a care facility so he could be stabilized.

We tried unsuccessfully to get him help - including submitting a state application for residential treatment last December, which to this day remains in limbo. He had multiple interactions with professionals who expressed to the family that he needed intensive treatment, but who explained that unless he agreed to voluntary emergency treatment, all our hands were tied because of the extremely restrictive danger standard in Maryland. This chorus of concern included a number of mental health practitioners, his primary care physician and mental health crisis teams in two jurisdictions and actively involved family members. And this situation continued, even after two of my siblings were designated as guardians.

The law needs to specify that the evaluation of a person exhibiting extreme mental illness include all available psychiatric and medical history, personal history and not just the visible behavior in any given moment in time. My brother is quite intelligent and has broad experience and background in the mental health field – as a patient, a student and a counselor. So, even in a deteriorated mental state, if he is being evaluated, he knows what to say and how to act in order to create an impression that will temporarily appease people.

It wasn't until he got arrested for inappropriate behavior last January and was in the detention center, that we were able to prevail upon a District Court Commissioner to issue an Emergency Petition. Then, he reluctantly agreed to continue inpatient psychiatric treatment at the hospital (as an alternative to pre-trial detention), but we had no ability to compel him to continue treatment on an involuntary basis, because we couldn't prove that he met Maryland's impractically difficult threshold of immediate danger to himself or others. Thankfully, he agreed to continue inpatient treatment because he said "liked the food" there. Otherwise, he said he was going to check himself out of the hospital psych ward, and would have ended up literally on the street in freezing temperatures with an uncharged cell phone and no money; with family members having absolutely no ability to even contact him. Thankfully, we were able to convince the hospital psych ward staff to keep him for an unusually long three-week period and then to secure wraparound community services. This took me at least 40 or 50 hours of intensive research, cold-calling service providers, networking and pleading with different programs to accept him.

Looking back a year later, my brother agrees that, at the time, he was unable to make rational decisions for his care, and that if he had not happened to agree to stay in the hospital, he would be tremendously worse off today. Coming up on the one-year anniversary of his arrest, he thanked me and my siblings for advocating so strongly to get him the care he needed but was resisting.

This danger standard needs to change as soon as possible! And the public safety and public health community need to recognize that many issues constitute "harm to oneself and others," including deteriorating mental health, disordered thinking and irrational choices, unacceptable and erratic social behavior, delusions, and failure to take prescribed medications, perform basic hygiene and eat regular meals. Schizophrenia is in itself a terrible, painful disease for its victims and their families. There would never be a medical standard to require kidney patients to wait until their renal failure is imminently life-threatening before they were allowed to access necessary treatment.

Thank you for your careful review of this matter - both for the benefit of mentally ill people and for our society at large. Whenever there is a school shooting or other acts of extreme violence, we hear a lot of talk about the need to fix the mental health system. Then those calls to action die down until the next catastrophic event. I hope that we can at least correct this particular obstacle to getting people the help they need but cannot necessarily request for themselves.

Sincerely,

Ellen Kobler